FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0010660

Facility Name: Carlyle Healthcare Center

Address: 501 Clinton Street (Number) Carlyle (City) 62231 (Zip Code)

County: Clinton

Telephone Number: 618-594-3112 **Fax #** 618-594-2393

IDPA ID Number: 37-0997048001

Date of Initial License for Current Owners: 04/01/1969

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Dave Reis **Telephone Number:** 217-228-1950

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) David Reis, President
(Firm Name & Address) WDM Computer Services Inc. 1900 Harrison St. Quincy. Ill 62301
(Telephone) 217-228-1950 Fax # 217-222-6053

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	51	Skilled (SNF)	51	18,666	1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,888	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	119	TOTALS	119	43,554	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,736		2,723	19,459	8
9	SNF/PED					9
10	ICF	366	14,283		14,649	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,102	14,283	2,723	34,108	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.31%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 04/01/1969

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 19 and days of care provided 2,723

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 2004 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Carlyle Healthcare Center # 0010660 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	241,366	11,180	6,139	258,685		258,685		258,685			1
2	Food Purchase		171,685		171,685		171,685	(6,712)	164,973			2
3	Housekeeping	108,348	18,235		126,583		126,583		126,583			3
4	Laundry	77,870	13,813	719	92,402		92,402		92,402			4
5	Heat and Other Utilities			110,898	110,898		110,898		110,898			5
6	Maintenance	97,762	30,982	26,989	155,733		155,733		155,733			6
7	Other (specify):*											7
8	**TOTAL General Services**	525,346	245,895	144,745	915,986		915,986	(6,712)	909,274			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	1,454,941	192,918	4,620	1,652,479		1,652,479	(8,746)	1,643,733			10
10a	Therapy	111,422	3,259	88,952	203,633		203,633		203,633			10a
11	Activities	83,282	12,059	24,312	119,653		119,653		119,653			11
12	Social Services	26,076		2,789	28,865		28,865		28,865			12
13	Nurse Aide Training											13
14	Program Transportation	3,091	2,356		5,447		5,447	(2,164)	3,283			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,678,812	210,592	124,273	2,013,677		2,013,677	(10,910)	2,002,767			16
	C. General Administration											
17	Administrative	171,754			171,754		171,754	(50,000)	121,754			17
18	Directors Fees											18
19	Professional Services			286,632	286,632		286,632	(216,588)	70,044			19
20	Dues, Fees, Subscriptions & Promotions			30,859	30,859		30,859	(24,612)	6,247			20
21	Clerical & General Office Expenses	103,620	15,597	14,083	133,300		133,300	414	133,714			21
22	Employee Benefits & Payroll Taxes			341,138	341,138		341,138	(6,390)	334,748			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,135	12,135		12,135	669	12,804			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			86,908	86,908		86,908		86,908			26
27	Other (specify):* Sales Tax			3,771	3,771		3,771	(3,771)				27
28	**TOTAL General Administration**	275,374	15,597	775,526	1,066,497		1,066,497	(300,278)	766,219			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,479,532	472,084	1,044,544	3,996,160		3,996,160	(317,900)	3,678,260			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Carlyle Healthcare Center #0010660 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			110,315	110,315		110,315	1,863	112,178			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,240	26,240		26,240	(10,944)	15,296			32
33	Real Estate Taxes			30,950	30,950		30,950		30,950			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			759	759		759		759			35
36	Other (specify):* **Contributions**			1,260	1,260		1,260	(1,260)				36
37	**TOTAL Ownership**			169,524	169,524		169,524	(10,341)	159,183			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation		2,356		2,356		2,356		2,356			38
39	Ancillary Service Centers		22,010		22,010		22,010	(5,700)	16,310			39
40	Barber and Beauty Shops		2,584	11,288	13,872		13,872		13,872			40
41	Coffee and Gift Shops		12,292		12,292		12,292		12,292			41
42	Provider Participation Fee			65,387	65,387		65,387		65,387			42
43	Other (specify):* **Bad Debts**			3,819	3,819		3,819	(3,819)				43
44	**TOTAL Special Cost Centers**		39,242	80,494	119,736		119,736	(9,519)	110,217			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,479,532	511,326	1,294,562	4,285,420		4,285,420	(337,760)	3,947,660			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,204)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(8,746)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,065)	30		9
10	Interest and Other Investment Income	(10,944)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,508)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,771)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,164)	14		16
17	Non-Care Related Fees	(58,280)	19		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,260)	36		20
21	Owner or Key-Man Insurance	(6,390)	22		21
22	Special Legal Fees & Legal Retainers	(227)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,819)	43		24
25	Fund Raising, Advertising and Promotional	(24,701)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule **Pharmacy Billing**	(5,700)	39		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (133,779)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(205,522)		34
35	Other- Attach Schedule **Schedule XI**	1,541	30	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (203,981)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (337,760)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Carlyle Healthcare Center

ID# 0010660

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Carlyle Healthcare Center # 0010660 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,712)	0	0	0	0	0	0	0	0	0	0	(6,712)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,712)	0	0	0	0	0	0	0	0	0	0	(6,712)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(8,746)	0	0	0	0	0	0	0	0	0	0	(8,746)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(2,164)	0	0	0	0	0	0	0	0	0	0	(2,164)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(10,910)	0	0	0	0	0	0	0	0	0	0	(10,910)	16
	C. General Administration													
17	Administrative	0	(50,000)	0	0	0	0	0	0	0	0	0	(50,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(58,507)	(158,081)	0	0	0	0	0	0	0	0	0	(216,588)	19
20	Fees, Subscriptions & Promotions	(24,701)	89	0	0	0	0	0	0	0	0	0	(24,612)	20
21	Clerical & General Office Expenses	0	414	0	0	0	0	0	0	0	0	0	414	21
22	Employee Benefits & Payroll Taxes	(6,390)	0	0	0	0	0	0	0	0	0	0	(6,390)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	669	0	0	0	0	0	0	0	0	0	669	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(3,771)	0	0	0	0	0	0	0	0	0	0	(3,771)	27
28	**TOTAL General Administration**	(93,369)	(206,909)	0	0	0	0	0	0	0	0	0	(300,278)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(110,991)	(206,909)	0	0	0	0	0	0	0	0	0	(317,900)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Carlyle Healthcare Center # 0010660 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	476	1,387	0	0	0	0	0	0	0	0	0	1,863	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,944)	0	0	0	0	0	0	0	0	0	0	(10,944)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(1,260)	0	0	0	0	0	0	0	0	0	0	(1,260)	36
37	**TOTAL Ownership**	(11,728)	1,387	0	0	0	0	0	0	0	0	0	(10,341)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(3,819)	0	0	0	0	0	0	0	0	0	0	(3,819)	43
44	**TOTAL Special Cost Centers**	(3,819)	0	0	0	0	0	0	0	0	0	0	(3,819)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(126,538)	(205,522)	0	0	0	0	0	0	0	0	0	(332,060)	45

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Dorothy Messick	51	St. Vincents Home Inc.	Quincy	WDM Health Scvs	Quincy	Mgmt/Leasing
Ann Reis	24	Clinton Manor	New Baden			
Sue Gray	24					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation	$	WDM Health Services Inc.		$ 1,387	$ 1,387	1
2	V								2
3	V	19	Management	225,000	WDM Health Services Inc.		63,739	(161,261)	3
4	V	19	Accounting		WDM Health Services Inc.		2,868	2,868	4
5	V	21	Office Supplies		WDM Health Services Inc.		414	414	5
6	V	20	License Fees		WDM Health Services Inc.		89	89	6
7	V	19	Legal		WDM Health Services Inc.		57	57	7
8	V	19	Consultant		WDM Health Services Inc.		255	255	8
9	V	24	Training/Seminar		WDM Health Services Inc.		669	669	9
10	V								10
11	V	17	Officer Wages	100,000	St.Vincents Home Allocation		50,000	(50,000)	11
12	V								12
13	V								13
14	Total			$ 325,000			$ 119,478	$ * (205,522)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Dorothy Messick	President		51.00		20	50.00	Wages	$ 100,000	17-1	1
2	Ann Reis	Secretary		24.00		19	48.00				2
3	Sue Gray	Treasurer		24.00		20	50.00				3
4											4
5	Dorothy Messick	President	St. Vincents			20	50.00				5
6	Ann Reis	Secretary	St. Vincents			19	48.00				6
7	Sue Gray	Treasurer	St. Vincents			20	50.00				7
8											8
9	Carlyle Healthcare Ownes St.Vincents			100.00							9
10	WDM Health Services		Management						225,000	19-3	10
11	Ann Reis		Clinton			2	4.00				11
12											12
13								TOTAL	$ 325,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WDM Health Services Inc.
Street Address: 1900 Harrison
City / State / Zip Code: Quincy,IL 62301
Phone Number: (217-228-1950
Fax Number: (217-222-6053

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Management	Management Fees	353,000	2	$ 100,000	$ 100,000	225,000	$ 63,739	1
2	19	Accounting	Management Fees	353,000	2	4,500		225,000	2,868	2
3	19	Consultant	Management Fees	353,000	2	650		225,000	414	3
4	21	Office Supplies	Management Fees	353,000	2	139		225,000	89	4
5	19	Legal	Management Fees	353,000	2	90		225,000	57	5
6	20	License Fees	Management Fees	353,000	2	400		225,000	255	6
7	24	Seminar/Training	Management Fees	353,000	2	1,050		225,000	669	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 106,829	$ 100,000		$ 68,091	25

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	First National Bank		X	Mortgage	$9,500.00	08-20-02	$ 880,697	$ 722,462	08-19-05	5.7500	$ 26,240	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First National Bank		X	Equip/Sprikler Loan	$1,900.00	12-17-04	100,000	100,000	12-17-09	6.0000		6
7												7
8												8
9	TOTAL Facility Related				$11,400.00		$ 980,697	$ 822,462			$ 26,240	9
	B. Non-Facility Related*											
10	Investment Interest										(10,944)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (10,944)	14
15	TOTALS (line 9+line14)						$ 980,697	$ 822,462			$ 15,296	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Carlyle Healthcare Center # 0010660 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 45,930	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 43,063	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,867)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 43,063	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ *30950	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	41,760	8
	2000	41,924	9
	2001	41,978	10
	2002	42,606	11
	2003	43,063	12

* To Reflect amount for Nursing Home , difference of 12113 is allocated to Assisted Living

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Carlyle Healthcare Center COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 0010660

CONTACT PERSON REGARDING THIS REPORT Dave Reis

TELEPHONE 217-228-1950 FAX #: 217-222-6053

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-08-18-353-005	Nursing Home	$ 42,589.16	$ 30,476.00
2.	08-08-18-353-004	Nursing Home	$ 474.20	$ 474.20
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 43,063.36	$ 30,950.20

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 69,374 B. General Construction Type: Exterior Brick Frame Wood,Steel,Concrete Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Medical Clinic Building 2205sq ft
Krebs Village 11112 sq ft 6 buildings
Villa Catherine Assisted Living 8334 sq ft 12 Units

No Expenses are in schedule V as they are all separate Divisions

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	48,738,720	1969	$ 103,500	1
2					2
3	TOTALS	48,738,720		$ 103,500	3

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	44		1969	1969	$ 30,426	$	30	$	$	$ 30,426	4
5	4		1988	1988	99,400	3,050	30	3,050		53,026	5
6	1		1977	1977	21,293	670	30	670		19,696	6
7	25		1973	1973	138,148		30			138,148	7
8	3		1993	1993	399,471	12,287	30	12,287		159,029	8
	Improvement Type**										
9	42 BUILDING ADDTN			1974	183,451	2,581	30	2,581		183,451	9
10	GERIATIC CENTER			1975	15,496	522	30	522		15,496	10
11	REHAB CENTER			1978	10,750	334	30	334		9,649	11
12	SPRINKLER			1974	32,694		25			32,694	12
13	BUILDING IMPROVMT			1975	14,572		20			14,572	13
14	BUILDING IMPROVMT			1970	1,588		20			1,588	14
15	BUILDING IMPROVMT			1973	3,328		20			3,328	15
16	BUILDING IMPROVMT			1974	825		20			825	16
17	PLAN OF CORRECTN			1975	21,969		20			21,969	17
18	GUARDS			1980	1,379		8			1,379	18
19	ALARM SYSTEM			1980	1,200		8			1,200	19
20	BUILDING IMPVMT GARAGE			1984	12,050		15			12,050	20
21	LAND IMPROVMTS			1987	37,715	1,735	20	1,735		33,107	21
22	BUILDING IMPVMT			1988	30,824		20	1,541	1,541	25,169	22
23	BUILDING ADTN GLASS ENCLOSER			1986	319,491	9,810	30	9,810		192,630	23
24	ROOM REMODELING			1988	16,596	509	30	509		8,853	24
25	ROOM REMODELING			1989	1,948	60	30	60		1,032	25
26	WINDOWS			1989	3,230	100	30	100		1,681	26
27	ROOF			1989	11,294	353	30	353		5,888	27
28	SMOKE DET			1980	2,204		8			2,204	28
29	BUILDING IMPVMT			1993	4,932		10			4,932	29
30	HANDRAILS			1991	6,574		8			6,574	30
31	CUBICLE CURTAINS			1992	8,415		10			8,415	31
32	FRONT PORCH ADTN			1997	85,961	2,377	33	2,377		18,706	32
33	ELEVATOR			1997	83,288	3,834	20	3,834		29,168	33
34	LANDSCAPING/RAILING			1997	8,550	526	15	526		3,994	34
35	LAND IMPROVMTS			1993	51,227	3,199	15	3,199		38,428	35
36	ROOF REPAIR			1995	8,974	875	10	875		8,488	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	FLOOR TILE	1995	$ 7,178	$ 445	15	$ 445	$	$ 4,292	37
38	FLOOR CORRECTION	1999	28,360	1,305	20	1,305		8,047	38
39	HALLWAY REMODELING	1999	10,315	957	15	957		5,685	39
40	NEW ROOF CTR/BOILER	2000	19,203	1,423	15	1,423		7,139	40
41	NEW GARAGE	2001	51,030	1,564	30	1,564		5,921	41
42	LANDSCAPING	2001	20,000	1,228	15	1,228		4,673	42
43	CONCRETE LOT/LIGHTING	2001	25,100	1,542	15	1,542		5,864	43
44	WINDOWS	2001	82,000	3,771	20	3,771		12,997	44
45	CENTER ROOF	2003	29,822	1,371	20	1,371		2,862	45
46	DINNING ROOM WINDOWS	2003	41,266	1,897	20	1,897		2,929	46
47	NEW PATIO	2003	73,579	3,384	20	3,384		6,740	47
48	TRANSFORMER FOR BUILDING	2004	15,008	199	20	199		199	48
49	SPRINKLER MIDDLE SECTION	2004	63,606	250	20	250		250	49
50	HOT WATER HTR	2004	3,285	34	8	34		34	50
51	FIRE DOORS MIDDLE SECTION	2004	5,302	59	15	59		59	51
52	TUCKPOINTING	2004	6,835	228	10	228		228	52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,151,152	$ 62,479		$ 64,020	$ 1,541	$ 1,155,714	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 450,191	$ 40,779	$ 42,166	$ 1,387	8	$ 206,742	71
72	Current Year Purchases	29,714	2,635	2,635		8	2,635	72
73	Fully Depreciated Assets	47,170					47,170	73
74								74
75	TOTALS	$ 527,075	$ 43,414	$ 44,801	$ 1,387		$ 256,547	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	BUS	1998	$ 17,531	$	$	$		$ 17,531	76
77	FACILITY	2000 DODGE VAN	2001	17,724	3,357	3,357		5	13,400	77
78										78
79	ADM AUTO		2001		1,065		(1,065)			79
80	TOTALS			$ 35,255	$ 4,422	$ 3,357	$ (1,065)		$ 30,931	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,816,982	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 110,315	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 112,178	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,863	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,443,192	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	ADM AUTO	$ 19,172	$ 1,065	$ 19,172	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 19,172	$ 1,065	$ 19,172	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 759 Description: Dishwasher
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				22,010		22,010	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Pharmacy Billing						(5,700)		(5,700)	13
14	TOTAL			$		$	$ 16,310		$ 16,310	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Carlyle Healthcare Center # 0010660 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 183,350	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	642,099		3
4	Supply Inventory (priced at FIFO)	10,562		4
5	Short-Term Investments	684,383		5
6	Prepaid Insurance	30,969		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,551,363	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	(127,772)		12
13	Land	128,950		13
14	Buildings, at Historical Cost	3,186,514		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	721,504		16
17	Accumulated Depreciation (book methods)	(2,050,006)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,859,190	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,410,553	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 129,109	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	100,000		29
30	Accrued Salaries Payable	153,904		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,012		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(2,467)		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 429,558	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	722,462		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Income Trusts	50,704		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 773,166	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,202,724	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,207,829	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,410,553	$	48

***(See instructions.)**

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,336,464	1
2	Restatements (describe):		2
3	Prior years Federal Income Tax adjustments	(30,753)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,305,711	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(157,484)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Other Divisions	59,602	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (97,882)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,207,829	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,966,733	1
2	Discounts and Allowances for all Levels	(14,398)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,952,335	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	44,507	6
7	Oxygen	22,264	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 66,771	8
	C. Other Operating Revenue		
9	Payments for Education	11,519	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	12,464	12
13	Barber and Beauty Care	13,471	13
14	Non-Patient Meals	5,204	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	27,661	17
18	Sale of Supplies to Non-Patients	8,746	18
19	Laboratory	4,545	19
20	Radiology and X-Ray	40	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 83,650	23
	D. Non-Operating Revenue		
24	Contributions	2,070	24
25	Interest and Other Investment Income***	10,944	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 13,014	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached List	12,166	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,166	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,127,936	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	915,986	31
32	Health Care	2,013,677	32
33	General Administration	1,066,497	33
	B. Capital Expense		
34	Ownership	169,524	34
	C. Ancillary Expense		
35	Special Cost Centers	54,349	35
36	Provider Participation Fee	65,387	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,285,420	40
41	**Income before Income Taxes (line 30 minus line 40)****	(157,484)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (157,484)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,032	2,088	$ 46,176	$ 22.11	1
2	Assistant Director of Nursing	1,934	2,038	43,217	21.21	2
3	Registered Nurses	14,859	15,661	287,763	18.37	3
4	Licensed Practical Nurses	18,629	19,794	325,367	16.44	4
5	Nurse Aides & Orderlies	72,159	75,803	752,418	9.93	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	7,657	8,195	111,422	13.60	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,982	2,078	25,260	12.16	9
10	Activity Assistants	6,366	6,672	58,022	8.70	10
11	Social Service Workers	1,885	1,973	26,076	13.22	11
12	Dietician					12
13	Food Service Supervisor	2,691	2,842	36,370	12.80	13
14	Head Cook	1,507	1,659	16,495	9.94	14
15	Cook Helpers/Assistants	9,358	10,226	94,526	9.24	15
16	Dishwashers	13,807	14,241	93,975	6.60	16
17	Maintenance Workers	7,509	7,901	97,762	12.37	17
18	Housekeepers	13,076	14,164	108,348	7.65	18
19	Laundry	9,286	9,902	77,870	7.86	19
20	Administrator	2,088	2,088	71,754	34.36	20
21	Assistant Administrator					21
22	Other Administrative	2,088	2,088	100,000	47.89	22
23	Office Manager	2,082	2,274	30,244	13.30	23
24	Clerical	5,515	5,907	73,376	12.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Transportation	367	391	3,091	7.91	33
34	TOTAL (lines 1 - 33)	196,877	207,985	$ 2,479,532 *	$ 11.92	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	117	$ 6,139	1-3	35
36	Medical Director		3,600	9-3	36
37	Medical Records Consultant	24	2,820	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	144	1,800	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	50	2,789	12-3	45
46	Other(specify) Religious		24,312	11-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	335	$ 41,460		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joann Brave	ADM		$ 71,754
Dorothy Messick	WK Officer	51	100,000
	(see page 6)		
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 171,754

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Herman Bodewes	Legal	$ 3,352
	less Dec 03	(227)
WDM Computer Inc.	Accounting	50,480
	Consulting	7,800
WDM Health Serv Inc.	Management	225,000
	(see pg 6)	
Non Allow		(58,280)
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 228,125

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 88,919
Unemployment Compensation Insurance	20,827
FICA Taxes	184,501
Employee Health Insurance	35,523
Employee Meals	395
Illinois Municipal Retirement Fund (IMRF)*	
401k Plan Expenses	2,922
401k Audit	600
Officer Health/Life Ins	6,390
Employee Physicals	1,061
Non Allow	(6,390)
TOTAL (agree to Schedule V, line 22, col.8)	$ 334,748

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,190
Advertising: Employee Recruitment	1,098
Health Care Worker Background Check	
(Indicate # of checks performed 42)	568
Corp Fees	280
Subscriptions	1,121
Advertising	24,701
Sec Of State	901
Less: Public Relations Expense	( )
Non-allowable advertising	(24,701)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,158

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See Attached List	12,135
Entertainment Expense	( )
(agree to Sch. V,	
TOTAL line 24, col. 8)	$ 12,135

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **8**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **20,151** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,387**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **395** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **5,204**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **2,164**
c. What percent of all travel expense relates to transportation of nurses and patients? **50**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? N
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **N**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.